THE CREATION OF MEDICARE AND MEDICAID in 1965 put health policy on the path to becoming the largest category in the federal budget. The federal government had long been involved in various activities to promote health; for example, spending on facilities for veterans’ medical care began early in the nineteenth century. By 1953, when President Dwight D. Eisenhower (1953–1961) created the Department of Health, Education and Welfare (HEW), the federal government regularly conducted public health investigations, regulated food safety, financed hospital construction and medical education, and made grants for biomedical research.

Of course, periodically during the twentieth century, Congress and the president considered but rejected establishing a national health insurance system. The legislative breakthrough of 1965 created health insurance programs for the elderly and the poor, but it set an important precedent—health care was now an “entitlement” for these groups. If people met the program’s eligibility requirements, then the federal government (with substantial assistance from state governments in the case of Medicaid) guaranteed payment for their medical care by participating providers. This guarantee had an open-ended impact on the budget—more money would be spent as both the number of beneficiaries and the costs of providing care increased.

Spending on Medicare and Medicaid quickly proved to be much higher than was expected at the time of enactment, primarily due to provider-friendly payment systems; the 1972 expansion of Medicare to cover those with end-stage renal disease, for example, was another notable contributor. By 1973, a rhetoric of “cost crisis” had become widespread, and President Richard M. Nixon (1969–1974) and Congress began to consider controls for these programs. Nixon also proposed a comprehensive plan for health insurance, a central component of which was an employer mandate, which for many reasons failed in Congress.¹

One reason the plan failed was that by this time, Nixon had alienated Congress by threatening its “power of the purse.” Article I of the U.S. Constitution prevents agencies from spending funds unless they receive appropriations from Congress. This implies that once funds are appropriated, agencies should spend them, except in extraordinary circumstances. Nixon disagreed, and shortly after his 1972 reelection, he refused to spend, or impounded, some appropriated funds, claiming that the programs were wasteful. Congress rightly believed that Nixon’s action was unconstitutional, and it responded with the Congressional Budget and Impoundment Control Act of 1974. This law severely limited presidential authority on impoundments, but more important, it supplemented the long-standing congressional authorizations and appropriations processes with a new process by which Congress would establish its own budget.

NATIONAL HEALTH EXPENDITURES DATA AND FEDERAL BUDGET FUNCTIONS

According to the federal government’s National Health Expenditures data, in calendar year 2012 (the most recent year available as of this writing), spending on health care in the United States was $2.79 trillion. This was 17.2 percent of the nation’s gross domestic product (GDP). These data show the federal government spent $732 billion, and state and local governments spent $497 billion, but these figures exclude government health spending that was financed by employee payroll taxes and premiums paid to the Medicare trust funds.²
Turning to federal government budget data on health spending, one useful categorization is “budget functions,” which breaks federal spending into about twenty major categories. For fiscal year 2013 (the most recent year for which data are available), which ran from October 1, 2012, to September 30, 2013, the Treasury Department reported that outlays for function 550 Health were $357 billion. Outlays are liquidations of obligations or, less formally, cash payments. The typical purposes of outlays in the health budget function are to reimburse medical providers for services they provide to patients, compensate civil servants in the Department of Health and Human Services (HHS), pay contractors for administering health insurance programs, grant funds to medical researchers housed at academic institutions and to states and localities for providing services, and pay for acquiring physical assets for the federal government, such as building a hospital on the campus of the National Institutes of Health (NIH).

The budget’s “health” function is not intended to be a comprehensive measure of all government health spending. That function includes one of the federal government’s most expensive health programs, Medicaid, along with many other programs in its “health care services” subfunction 551, and separate subfunctions for “health research training” and “consumer and occupational health and safety.” However, there is an entirely separate budget function for Medicare, function 570, which had $498 billion in outlays in fiscal year 2013. Other budget subfunctions with substantial health spending were 703 Hospital and Medical Care for Veterans (where fiscal year 2013 outlays exceeded $50 billion) and 051 Defense, Military Personnel (where funding for health care in fiscal year 2012 was $52 billion, almost 10 percent of the regular defense budget).3

**DISCRETIONARY SPENDING AND THE APPROPRIATIONS AND AUTHORIZATIONS COMMITTEES**

While congressional budget resolutions group spending by budget functions, the authorizations and appropriations processes are much more important for the allocation of funds to departments and programs. Here, the critically important distinction is between discretionary and mandatory spending.

**Discretionary Spending**

By definition, a discretionary spending program is one that each year receives budget authority through the annual appropriations process. Budget authority is permission given to a department to obligate funds now or in the future. Liquidations of these obligations are outlays. In programs that pay personnel, the conversion speed of budget authority to outlays, which is known as the “spend-out rate,” is usually rapid, with the agency spending almost all of its budget authority in that year. In programs that purchase assets, spend-out rates can be much slower. Twelve annual appropriation bills are drafted by the appropriations committees of the House and Senate, after which they are considered by the whole House and Senate.

Almost all of the major operations by government, for the administration of health care services and the regulation of health, and almost all of the major grants and contracts for particular projects, are discretionary. If Congress were to follow routinely the schedule it has set out for itself, this would mean that by October 1 of each year, the major discretionary health programs would receive budget authority in four appropriations bills: the Labor, Health, and Human Services, and Education bill (commonly called Labor-H); the Defense bill; the Military Construction and Veterans Affairs bill; and the Agriculture bill, which includes the Food and Drug Administration (FDA). Congress and the president have routinely failed to enact these bills on time, especially in recent years. Among the many reasons for the recent delays is the increased ideological polarization between the two major political parties. Delays for the Labor-H bill are more longstanding due to riders, provisions that affect spending but are more controversial because of their policy impact, such as bans on using government funds to finance abortions or family planning.

When regular appropriations bills are not enacted by the target date of October 1, Congress typically passes a continuing resolution, or CR, a law that gives departments budget authority for a limited period of time, usually from several weeks to several months. These bills typically require departments to spend at the current rate: the amount of spending authorized for the previous year, with no upward adjustments for inflation or for an increased demand for services. Departments also cannot use funds for purposes that were not in the previous year’s budget, which is known as “no new starts.”

In some years, numerous continuing resolutions have been required before Congress and the president finally agreed on the discretionary appropriations amounts and related policy disputes. The Library of Congress maintains a very helpful Web page on the “Status of Appropriations Legislation,” which can be used to keep track of the progress, or lack of it, on these bills.4 On several occasions Congress has failed to pass even a continuing resolution, which, under a strict interpretation of the U.S. Constitution, has meant that departments must cease their non-essential operations and send their unfunded employees home without pay. Perhaps as bad has been the regular threat of government shutdowns, which has forced departments to plan for shutdowns rather than carry out more productive activities.5
Authorizing Committees

While the provision of budget authority to discretionary programs is under the sole jurisdiction of appropriators, these programs typically must receive an authorization before being funded. The authorization committees have the responsibility to draft these bills before floor consideration. The Senate committee with the most jurisdiction in the discretionary health area is the cutely named Health, Education, Labor and Pensions Committee, or HELP. Armed Services and Veterans' Affairs oversee the aforementioned major health services programs for current and ex-military, and the same is the case in the House. The House, however, has no full committee that includes health in its title. There is a Health Subcommittee, which has jurisdiction over most nonmilitary discretionary health programs; it is part of the Energy and Commerce Committee, which is one of the House’s most powerful committees.

Authorizing committees are responsible for creating departments and programs, and then overseeing their creations’ behavior through hearings and investigations. These committees periodically try to pass revisions to their authorizations, subject to time being available on the legislative calendars. Authorization provisions are often tremendously important. For example, they have established the conditions of federal assistance for hospital construction, the rules for carrying out biomedical research, and the process for the regulation of food and drugs. Appropriators usually, but not always, defer to these committees’ policy guidance.

For discretionary spending, authorizing committees also write into their bills permission for the appropriators to provide budget authority. That is, the process is intended to have two steps: first, the authorizers establish a program in great detail and provide a rough guide to how much funding could be provided; second, the appropriators decide how much funding will be provided. For the first step, the Congressional Budget Office (CBO), a nonpartisan group of budget experts, supplies a cost estimate that accompanies each bill when it is reported to the whole House or Senate. By convention, these projections assume that the appropriators will supply the full amounts of discretionary budget authority that are permitted in the authorizations and estimates the resulting outlays based on historical spending rates.

Despite that “full funding” assumption, discretionary means just that: the appropriators need not feel bound by what is often an authorizing committee’s desire to expand funding for the program it has designed. It is rather common for appropriations to come in below authorized levels. However, the term discretionary is also in one sense a misnomer. Consider the Veterans Health Administration (VHA), the country’s largest integrated health system, which is financed each year through the discretionary appropriations process. Practical and political realities require the appropriators to come close to the amount requested for this organization’s budget, and it has often been the case that appropriations have exceeded presidential requests. In fact, given the practice of late appropriations bills, in 2009, Congress decided to provide the VHA with an advance appropriation, which means that the appropriation bill funds spending for the following fiscal year. That is, any delay in passing the appropriation bill by October 1 will not hurt the VHA, because its budget for the year starting on that date will already have been enacted in the previous year. Agencies within HHS are not so fortunate.

MANDATORY SPENDING, THE TAXATION COMMITTEES, AND HEALTH-RELATED TAXATION

The programs that are truly fortunate regarding the timing of budget approvals are so-called mandatory programs. This term is even more of a misnomer than discretionary, if the implication is that this spending cannot be reduced. That is incorrect in most cases, though there is no question that changing mandatory spending is not easy. For example, spending on Medicare, a mandatory program, has occasionally been reduced from its projected level, but this has required expenditure of substantial political capital, given the opposition by powerful interests that benefit from the program.

Mandatory Spending

The simplest start to understanding this type of spending has again to do with committee jurisdictions. In contrast to discretionary spending, which requires action by the authorizations committees, for mandatory spending, the appropriations committees have been written out of the process. The authorizing committees have taken over the appropriators’ role by writing legislation that not only created a program but also provided that program with budget authority. Much like getting a beneficial card in the game Monopoly, a department with mandatory budget authority can go straight to the Treasury for its funding without having to get past the appropriators. So benefit payments for Medicare and Medicaid are mandatory, but the Centers for Medicare and Medicaid Services (CMS) must receive a discretionary appropriation to cover the costs of administering these programs.

Controlling Mandatory Health Care Spending

The authorization committees that control the most mandatory health spending are the Senate Finance Committee and the House Ways and Means Committee. These committees are especially powerful because they have exclusive jurisdiction over taxes and borrowing. This power can be politically
precarious, given the tendency of Americans to rebel against taxes and to worry about government debt. On the other
hand, jurisdiction over taxes has allowed these committees to greatly influence health policy, in two very different
ways—the power to not collect taxes and the power to dedicate taxes.

The power to not collect taxes is used when Congress
enacts tax preferences, which take many forms, including
deductions, credits, exemptions, exclusions, and deferrals. The
revenue losses from these preferences are called tax expendi-
tures. The largest health tax preference by far, estimated to cost
$203 billion in fiscal year 2013, is the exclusion from income
taxation of employer-provided medical insurance premiums
and medical care. It is also the costliest of all tax preferences,
more than double the revenue loss from allowing the deduc-
tion of mortgage interest for owner-occupied homes.6

There is no doubt that this benefit is economic income
to employees, but there is also no doubt that proposing to
include this compensation in the income tax base is politi-
cally dangerous. The exception that proves this rule is the
 provision suggested early during consideration of the Patient
Protection and Affordable Care Act (PPACA) to impose a
tax on so-called Cadillac health insurance plans, those
whose scope of benefits and low out-of-pocket costs for
employees requires high annual premiums. By limiting the
amount of private health insurance spending that can be
excluded from taxation, government can limit its revenue
losses and increase employee sensitivity to that spending.
The near-term impact of this limit on the tax preference was
greatly reduced in the adopted legislation after unions such
as the United Mine Workers, who had negotiated strong
health insurance coverage for those with very unhealthy
occupations, lobbied against it. However, because the legis-
lation did set a fixed dollar figure for the level at which the
tax will apply, under the current law, as costs increase over
time, more health insurance plans will become subject to the
tax. Anticipation of this effect has already produced a lobbying
campaign to amend the law.

Estimates of health tax expenditures, including eleven
smaller health tax expenditures listed by the Office of
Management and Budget, can be found in the Analytical
Perspectives volume of the president’s budget. This present-
tation is far less visible than the detailed descriptions of
regular health spending programs in the rest of the budget.
Like mandatory spending, health tax expenditures are not
subject to annual review by appropriators. Apart from the
occasional effort to carry out comprehensive reforms of the
health care system or the tax code, health tax provisions
receive very little scrutiny from the budget process.7

Medicare is a good example of the second benefit of
having exclusive jurisdiction over taxation. The taxation com-
mittes may dedicate revenues to programs that they control,
most notably through the Social Security Act of 1935.

Amendments to this act have created many programs, includ-
ing Supplemental Security Income, child support enforce-
ment, foster care and adoption assistance, “welfare” (now
known as Temporary Assistance for Needy Families), and
Medicare and Medicaid. (The House Energy and Commerce
Committee now has primary jurisdiction over Medicaid.)

By statute, Medicare’s Part A receives a share of payroll
tax receipts to pay for the hospital insurance program. This
dedication provides a source of budget authority separate
from the general revenues of the Treasury, which are pri-
marily from individual income taxes. As with Social Security,
advocates of the program wanted to insulate Medicare’s
finances from general revenues and the appropriations pro-
cess. The prior payment of dedicated taxes helped generate
widespread perceptions of earned rights to program bene-
fits, and Part A’s finances were segregated in a so-called trust
fund. Trust funds earn interest from the Treasury on the
surplus of dedicated receipts that are not used to pay current
benefits. The label trust also implies to some, mistakenly in
fact, that the funds are sufficient to pay for all benefits and
that they can never be used for other purposes.8

The trust fund structure is not the only approach for
health mandatory spending. Most of Medicare’s spending
on outpatient services and prescription drugs is financed by
general revenues and by premium payments from benefici-
aries. Those premiums, along with co-insurance payments
and substantial deductibles for inpatient hospital care,
amount to several thousand dollars annually for an average
beneficiary, who must either pay these costs directly or pur-
chase supplemental “Medigap” insurance to cover them.

Medicare premiums are not counted as taxes, but as
offsetting receipts, which are subtracted from outlays on the
spending side of the budget. Medicaid is financed out of
general revenues. The federal budget also includes taxes on
tobacco and alcohol intended to reduce demand for these
products, particularly among youth. These revenues are not
dedicated to related programs, such as for substance abuse,
though they have been used as offsets to allow increased
spending on health programs in general. Offsets are
increased revenues or reduced spending used to counteract
the deficit-increasing effects of a spending increase or tax
cut on the budget. A final financing source for health spend-
ing that deserves mention is government borrowing; because
the federal government routinely runs a budget deficit (an
excess of outlays over revenues), health spending contrib-
utes to the need to issue debt.

HEALTH BUDGETING IN
THE EXECUTIVE BRANCH

Presidents and the executive branch at their command
play a very significant role in health care budgeting. The
Budget and Accounting Act of 1921 gave the president the
responsibility to gather the spending estimates of agencies, modify them if desired, and present them as a comprehensive budget request to Congress. That act also created the General Accounting Office, now known as the Government Accountability Office (GAO), an agency of the legislative branch whose audits of health programs can be very influential.

The Budget and Accounting Act also led to the creation of a central budget office in the executive branch, which is now called the Office of Management and Budget (OMB). Its director is a political appointee, as are some subordinates; particularly important for health is the program associate director (PAD) for health. Health PADs typically have extensive political experience and have gone on to important health policy jobs, such as administrator of the CMS. Most of OMB’s employees are civil servants, hired for their neutral competence: technical skills in policy analysis, management, and budgeting that are used in service of both Democratic and Republican administrations.

Importance of the OMB in Health Care Funding

OMB has many roles, including coordination of the administration’s legislative program, but its most important responsibilities are to prepare the president’s budget request and to oversee the execution of enacted budgets. It periodically issues specific guidelines to agencies about these activities, and these publications are available on OMB’s Web page. Yet much of OMB’s budget preparation work is not transparent to the public. In general, executive budget preparation is viewed as providing confidential advice to the president.

The budget preparation process begins with the budget “call,” comprising broad guidance to departments about the president’s priorities and the exceptionally detailed Circular A-11 that shows the format in which budget requests should be prepared. The process of budget preparation within domestic departments is designed to respond by early fall to OMB’s requirements. Within HHS, for example, the various agencies, such as the NIH, Health Resources and Services Administration (HRSA), CMS, FDA, and Centers for Disease Control and Prevention (CDC), prepare requests that are reviewed by the department’s budget office and the HHS secretary, with support units such as the assistant secretary for planning and evaluation weighing in. Each of these major agencies has its own budget office that runs a similar process within the department.

Once departments submit their budget requests, OMB’s civil servant budget examiners (who are now formally called “resource management officers”) review those requests in consultation with their bosses and make tentative decisions about which of the department’s requests will be approved and which will be denied. The communication of these decisions to departments is called the “passback.”

Passback day is usually not a happy day in departments, for it is rare for OMB to let a department’s request through unscathed. A department proposal may be inconsistent with the president’s program, or the examiner may believe that the department failed to show that a proposal would be cost-effective, or there simply may not be enough funding available even for a well-justified program.

The next step in the process is potentially an appeal of the passback, which at its most serious stage can involve the HHS secretary petitioning directly the OMB director, senior White House staff, or the president. The word potentially is used because it is difficult to win appeals. Since in many years there has been substantial political concern about the size of the deficit and of the amount of government spending, the federal budget process has become a top-down process. This means that OMB has more influence than departments and that it takes a very strong argument to convince the White House to reverse its central budget office.

Performance versus Incrementalism

A distinctive element of executive budget preparation is its recent emphasis on what is broadly known as performance management. This approach seeks to replace a historically important method known as incrementalism, in which a proposed budget typically included only small changes to the previous year’s budget. Over the past century, periodic attempts have been made to replace incrementalism with a more rational one in which the government takes a comprehensive view of its spending, estimates the projected benefits of alternative paths, and if necessary make substantial changes to the current budget. Some efforts to move toward rational budgeting have been particularly unrealistic, but the most recent approach has produced some improvements in the executive branch process. It started in 1993 when Congress passed the Government Performance and Results Act (GPRA), which required agencies to produce strategic plans, report periodically on their program results, and integrate their plans and results measurements with budget requests, management of operations, and personnel systems.

The Government Performance and Results Act

Implementation of GPRA has had mixed effects. A particular challenge has been that it placed the onus on the executive branch even though the legislative branch has substantial influence through the authorizations process on the statutory goals required of the agency and similar influence through the appropriations process on the resources available to address those goals. When Congress has been controlled by a different party than controls the presidency, legislators have complained, sometimes with cause, that departments failed to consult with Congress about their strategic plans.
On the other hand, many health agencies have made much progress generating and using performance data. GPRA called for a shift of focus toward outcomes, the intended results of programs, rather than looking solely at agency activities and their immediate outputs. This approach is consistent with existing efforts such as the decennial Healthy People goal-setting process and with the aspiration of the health field more generally to make decisions based on evidence.

In an analysis of how major HHS agencies had implemented GPRA through 2006, David and George Fredrickson found that despite the outcomes focus required by law (e.g., on healthier Americans), agencies in practice tended to focus on their operations and outputs (e.g., on the amount of services delivered). CMS reported quantitative figures on payment accuracy, while NIH reported qualitative findings about how the agency generated scientific knowledge. Outcome measurement happens to be quite challenging for many HHS-funded operations, particularly when this requires monitoring of the many contractors and grantees that provide health services funded by HHS (e.g., in substance abuse and mental health services). But even if outcomes could be determined with complete confidence, this information would rarely provide a definitive answer to the question: “Should we spend more or less on this program?” Evidence of a poorly performing program may indicate the need for reform and even more spending, rather than the termination of efforts to attain an important goal.10

The GPRA Modernization Act of 2010 made a modest extension of GPRA’s aspirations, particularly to develop goals and strategies that cut across department jurisdictions. How far this approach can be pushed depends in part on how strongly the executive branch commits to it—but receptivity by Congress is also important. Though Congress mandated GPRA, the institution has often ignored department performance analyses. Many legislators are less interested in the cost-effectiveness of programs than they are in how much money will be spent, and especially where (in which states and districts) and on whom (beneficiaries, providers, grantees, and campaign donors).

While there is much truth to this characterization of congressional behavior, it can also be overstated. The appropriations committees require departments to supplement the president’s budget with a justification book. Running in the many hundreds of pages, these documents provide committee staff with extensive detail on discretionary budgets: on personnel, building construction and maintenance, major contracts, the previous year’s spending record and related accomplishments, and especially plans for new projects and programs. Agency leaders can expect many questions about these details, some about arcane matters, but also some about issues central to the agency’s operations. In hearings and through personal communications, legislators and their staff also ask about special projects of interest to subcommittee members. Projects for specific beneficiaries that are inserted into the budget by legislators are known as earmarks; compared to other areas of the budget, most health budget accounts have few earmarks.

A particularly cynical view of legislative disinterest in effectively controlling spending observes that legislators are among the first to blame agencies for “fraud, waste, and abuse” (FWA) in health spending, even though they have not given agencies the full ability to control it. For years, after an offhand comment by a GAO official that “perhaps 10 percent” of Medicaid spending was fraudulent, this ratio was cited by legislators as an authoritative number when they would call attention to the problem and, in some cases, blame administrators for this supposed magnitude. But the real magnitude of FWA is by definition hard to estimate; if the government knew how all the misspending took place, it would be much easier to reduce that amount. CMS has recently stated that it believes a better estimate of improper payments is about one-third of the 10 percent imaginary figure.

Controlling Fraud and Waste
Over the past few decades, genuine progress has been made in fraud control; CMS and the Department of Justice have repeatedly succeeded in prosecuting providers who fraudulently billed Medicare and Medicaid. Yet many experts believe that additional investments are warranted. Health spending auditors and prosecutors can return many multiples of their salaries by preventing payments that providers do not deserve. Congressional practice is to not count increased funding for this purpose (known as program integrity appropriations) against some budget limits, but this has not been enough incentive to entice Congress to make much larger appropriations. Controlling fraudulent spending also requires effective regulation, which can be a political challenge when an influential provider group opposes such regulation, as has been the case with bidding procedures for durable medical equipment.11

State governments have also opposed stricter regulations, such as for Medicaid matching policies. Over the years, many states have imposed various taxes and fees on Medicaid providers, the proceeds of which have been recycled into the state medical systems, but which have increased the gross costs of the state programs. This increased the effective match rate to state spending that is provided by the federal government. At times, federal budget officials have labeled these practices as scams and the like, and periodically the federal government has limited its budget exposure by tightening its rules, though with very generous adjustment periods for the innovative states.12

While health FWA is often in the political spotlight, more generally the practice of budget execution—the
implementation of enacted budgets—usually receives less attention than its importance. Implementation of the PPACA is the clear exception. OMB plays a central role in controlling budget execution. Departments must report periodically to OMB on how they are spending their funds and must receive approval during each quarter of the fiscal year to spend portions of their enacted budgets (known as appropriations). OMB's Office of Information and Regulatory Affairs reviews proposed major health regulations that can have large impacts on budget costs. Finally, OMB is responsible for issuing sequestration orders, which require budget cuts that are triggered by the failure of Congress and the president to meet certain budget targets.\textsuperscript{15}

To summarize, the executive budget preparation process is very hierarchical, with multiple deadlines and repeated adjustments from the point that a unit proposes its initial budget request. The process is very hard to observe from the outside. Although the process is oriented toward a rational approach, given the aforementioned delays in legislative budgeting, it's also fair to say that the executive process is often confused. How can it be possible to prepare a sensible budget request for next year when one does not know for months into the current year what the final approved budget is for that year? And that is not the only problem with how budget politics affects budget preparation and execution.

The 302 ceilings are used during the rest of the appropriations process to make sure that subcommittees do not pass bills that provide more funding than the total allowed by the budget resolution. Legislators may raise a point of order against bills that violate the 302b ceilings. In addition, the Budget Control Act of 2011 created annual dollar limits on the two subtotals of defense and nondefense discretionary spending.

**Budget Reconciliation**

The budget resolution's total for mandatory spending is distributed to the authorization committees. Important enforcement procedures are based on these policy totals. A budget resolution may include reconciliation instructions to these committees to report changes in law that, if enacted, would reduce mandatory spending and/or increase revenues. Reconciliation bills are particularly important in the Senate because they cannot be filibusted, so they have served as vehicles for important changes to major entitlements. For example, the Balanced Budget Act of 1997 planned significant reductions in Medicare payments to providers, and created the State Children's Health Insurance Program. That is, reconciliation has been used not only to reduce spending but also to increase spending on particular mandatory programs.\textsuperscript{14}

The other enforcement control for mandatory spending is called "paygo." This rule requires that if Congress wants to create new mandatory spending or to provide new tax cuts, it must offset the resulting deficit increases with cuts in existing mandatory spending or with new tax increases. This rule, which was put in place in 1990, was a significant barrier, though not the most important one, to adoption of the Clinton health reform plan. In contrast, the temporary expiration of the paygo rule enabled passage of the Medicare Modernization Act of 2003, which created a prescription drug plan for outpatient Medicare beneficiaries. The projected cost of this expansion was limited by that year's budget resolution to $400 billion over a ten-year estimating period, but no offset was required. Passage of this bill was controversial in many respects; the House leadership used questionable methods to gain passage of the bill on the floor, and some actuarial estimates of the bill's cost were higher than the $400 billion ceiling, but those estimates were prevented from being released to the public.\textsuperscript{13}

There are few defenders of the current congressional budget process, and for good reason. Over the past decade, Congress has frequently failed to pass a budget resolution. When this has happened, the cause has usually been policy disagreements between the parties over which they have been unwilling to compromise. Absent a budget resolution, the House and Senate set different ceilings for discretionary spending, making it more likely that there will be lengthy disputes over individual bills. Passage of the 2011 Budget
Control Act provided a substitute for budget resolution caps, but if the totals of this act are maintained over the next decade, the resulting nondefense discretionary spending will be less than 3 percent of GDP, which is below its percentage in 1962, when public expectations for government performance were much lower than they are today. For this reason, these projected cuts are widely believed to be politically unsustainable.

THE POLITICS OF HEALTH SPENDING CONTROL AND EXPANSION

The word unsustainable is more often used about mandatory spending for health care. For decades, the growth rate in federal health care spending has exceeded the growth rate of revenues. “Excess cost growth” can be also seen when comparing growth of the health sector of the economy to growth of the economy as a whole, and macroeconomic projections indicate that continuing this allocation of society’s resources toward health care will eventually slow economic growth. While health care cost growth has shrunk very recently, many projections assume significant excess cost growth over the coming decades. More spending on health benefits would crowd out spending in other parts of the budget and/or require large tax increases.

Some advocates have argued that this projected growth of health spending is a crisis, one that threatens the financial viability of the country. Using the code word entitlements, by which they mean Medicare, Medicaid, and Social Security, these advocates have called for major reductions to spending on these programs. They have supported their claims by drawing from seventy-five-year actuarial projections that show Medicare’s trust fund rapidly approaching insolvency. Other experts acknowledge that these projections show the need to shore up the program’s finances, but reject the crisis imagery and the reliance on highly uncertain long-term estimates. They suggest that as the country’s wealth increases, increased revenues can help close the financing gap, and they also note that the country still lacks an efficient and universal system for insuring for long-term care.

Public Response to Health Care Spending and Growth

Most of the public has not responded to warnings of a health care funding problem by embracing proposed cuts in health care spending or increases in taxes. One of the most telling examples was the hand-lettered signs at Tea Party rallies that screamed: “Get the Government’s Hands Off My Medicare!” However, that confusion about who runs Medicare is not shared by many elderly, or for that matter by many of their children; Medicare is one of the most successful and popular programs in U.S. history. In fact, the public is highly desirous of more spending on health in general. In public opinion polls, when asked whether government is spending “too little” or “too much” on health, the public typically chooses the former. For example, in 2012, Ellis and Stimson reported findings from the 2008 General Social Survey: when the public was asked about a range of public policies for which it was possible that “too little” was being spent, the option of “improving and protecting nation’s health” was their top choice. As is typical for such surveys, respondents were not simultaneously asked how reversing “too little” should be financed. A fundamental long-run question for health budgeting is thus: do we really want to increase spending for Medicare, Medicaid, and other health care payments if it will be financed by cuts to other spending and/or with higher taxes?

Many citizens and elected officials can be accused of ignoring that tradeoff, of respectively demanding and promising the proverbial free lunch. However, that criticism should not ignore the many plausible justifications for spending more on a broad range of health programs. Many rural and inner-city areas lack quality health care; HRSA budget increases might help. Substance abuse and mental health programs are quite serious; higher budgets for the Substance Abuse and Mental Health Services Administration and the VHA could assist those in need. Reductions in environmental pollution have saved many lives, including by reducing crime-stimulating exposures to lead; more research and enforcement funding for the Environmental Protection Agency could produce similar benefits. The CDC has an impressive record combating communicable diseases and other public health challenges. What are the chances that we won’t need to spend more on these areas as the world becomes even more interconnected and as climate change creates more disease vectors? Also, regarding records of accomplishments, the massive government investment in biomedical research has clearly paid off in increased health outcomes, an argument used to support doubling the NIH budget over the period 1998 to 2003 (though funding in constant dollars has declined slightly since 2003). Is there much reason to doubt that more research spending, such as the proposed mapping of the fine details of the brain, would fail to produce findings that would benefit us?

That earlier NIH budget increase came about because Senator Arlen Specter (R-PA; in office 1981–2011) and a broad coalition of supporters mobilized to convince elected officials about the merits of a budget increase. More generally, health budgeting involves a multitude of affected interest groups as well as influential think tanks and for-profit consulting firms. These organizations interact in an “issue network” that on a daily basis exchanges research findings and rhetorical arguments about current health policy issues. The shifting coalitions of advocates for different types of
health spending are often very influential, for they are well organized, geographically distributed, and politically skilled. There is not a legislator in the country who doesn’t know successful doctors and hospital executives or is unaware of the influence exercised by the insurance companies represented by America’s health insurance plans and by individual brokers.

Sometimes health provider interest groups have provided solutions to the financing challenges for expanded health spending. After the FDA was criticized for delays in its reviews of drug safety and efficacy in the mid-1990s, the pharmaceutical industry supported a proposal that they pay user fees to finance faster FDA reviews for generic drugs. Passage of the PPACA in 2010 was smoothed when major provider groups agreed that since expanded access would provide additional demand for their services, they would contribute new revenues, such as through excise taxes, to finance the law’s early costs. That bargain has not completely held, however; interest groups, such as the providers of durable medical equipment, are now lobbying to repeal the taxes that affect them.

In other cases, the influence of provider groups has been a substantial barrier to desirable budget savings. This is because the government’s health costs equal health providers’ incomes, a truism of health budgeting that suggests why the process is often politically challenging for elected officials. Nevertheless, many politicians prefer to claim that the policies they adopt to control health budgets will generate savings from providers’ pockets and not from the patients. One justification for this approach is that the incomes and profits of U.S. health providers are substantially higher than the incomes and profits of comparable quality providers in other rich countries. However, with the PPACA’s access expansion, the United States will need more providers in many important practice areas, limiting the potential for short-term savings. Over the longer run, the PPACA is projected to save substantial sums as it fosters new payment systems based on quality and as the government learns from numerous policy experiments authorized by the law.

Changing Health Funding Budgeting Procedures

U.S. budgeting has recently featured new procedures that some hoped would force difficult actions. One such approach for health budgets was the Sustainable Growth Rate Mechanism (SGR), which each year retroactively would reduce physicians’ fees paid by the Medicare program to offset previous spending that exceeded a target related to inflation. Under the fee-for-service method used by Medicare, individual physicians are rewarded for providing more services. The SGR was intended to impose collective responsibility among physicians for controlling the overall volume of services; all physicians were supposed to be punished for collectively exceeding the SGR target, whether they individually were contributing to the excess volume of services or not.

In practice, the SGR has been a failure. Repeatedly, Congress has voted to limit the adjustments; these actions have accumulated to schedule larger and larger cuts that will not be allowed to occur but that nevertheless are incorporated into budget projections. A related approach was the establishment of the “excess general revenue funding trigger,” which required the president to propose legislative changes for Medicare when it was funded with general revenues by more than an arbitrary 45 percent level. As with the SGR, this has not forced action.

Another procedural approach for generating health budget savings is to form a group of health policy experts, insulated from day-to-day politics, to propose specific savings that are backed by evidence. The highly respected Medicare Payment Advisory Commission has generated many such proposals, but its influence has been more through an “enlightenment effect” of building support over the long run for good ideas rather than stimulating quick action by Congress and the president—who are not insulated from politics. The PPACA creates a somewhat more powerful body, the Independent Payment Advisory Board (IPAB), which could force provider payment reductions in the future. Fifteen experts would recommend changes to Medicare’s fee schedule if spending exceeded a specified amount, and their proposals would be implemented by HHS unless Congress disapproved them on a fast-track schedule. However, the IPAB may already be obsolete, for it seems likely that a replacement for the SGR will extend the PPACA’s shift toward replacing fee-for-service payments with payments that reward the production of quality health outcomes.

Each adoption of a major health policy change, such as Medicare’s 1983 introduction of the prospective payment system for hospitals, has significantly changed health budgeting. In recent years there have been many proposals for large changes to the health sector, each accompanied by projections of budget savings. Among those that have not (yet) been adopted are a single-payer system, Medicare for All, replacing employer-based health insurance, block granting Medicaid, and a “premium support” to limit the government’s portion of Medicare costs. The prospects of these approaches were all greatly diminished by passage of the PPACA, especially after the Supreme Court upheld most of the law and the 2012 reelection of President Obama effectively endorsed the law’s continuation.

The PPACA’s backers argued sensibly that access expansion was a prerequisite for cost control and quality improvement. The truth of this assertion will be tested as
the law's benefits and mandates are phased in. Given its scope, full implementation of the law has been a tremendous challenge, and there will undoubtedly need to be significant changes made through both administrative and legislative actions. A particular challenge will be finding sufficient funds for administering the program. While the PPACA's authors used mandatory funding for administering parts of the law, opponents of the law have been fighting a rear-guard action against it by seeking to withhold the additional discretionary funding that is needed.

In sum, the PPACA has set in motion a dramatic transformation in how the country will budget for health; much uncertainty remains about how that transformation will proceed.

**INTERGOVERNMENTAL ASPECTS OF HEALTH BUDGETING**

In addition to federal budgeting for health, state and local governments also spend large amounts on health, often with matching assistance from the federal government. The largest state expenditures by far are for Medicaid. This program is typically the first or second largest component of state budgets, along with state spending on elementary and secondary education. States also spend large amounts on mental health and substance abuse services. Some local governments operate hospitals they own, many provide emergency medical services, and most provide public health services along with their states.

**Debating and Projecting the Costs of the PPACA**

Many authors have described the long and winding path to enactment of the PPACA, featuring ideological disputes about the extent to which government should guarantee health insurance, and political surprises such as the election of Scott Brown (R-MA; in office 2010–2013) to the Senate, which forced the Democrats to use budget reconciliation to pass critical elements of the reform. Just as important as these factors was how the bill's budgetary costs and health insurance access expansions were projected by the Congressional Budget Office.

In 1994, in his testimony on the health proposal submitted by the Clinton administration before the House Ways and Means Committee, Robert D. Reischauer made an unusual plea:

> With your indulgence, I would like to close my remarks on a more personal note than is typical for the testimony of the Director of the Congressional Budget Office. I have appeared before committees and subcommittees of the Congress well over 100 times. On each of these occasions I have started with some customary remarks concerning how pleased I was to have the opportunity to testify.

> I did not start off that way today, I did not because I have considerable foreboding that the information contained in my statement and in the CBO report might be used largely in destructive rather than constructive ways—that is, it might be used to undercut a serious discussion of health reform alternatives or to gain some short-term partisan political advantage. I am not a babe in the woods who thinks that it is wrong to use CBO's objective analyses and estimates in the give-and-take of the political fray. But when this has happened in the past, it has quickly died down, and then CBO's input has been put to use in constructive ways to shape better policy.

> I fervently hope that will be the case once again. But I have not been encouraged by the recent debate, which at times has degenerated into semantic mud wrestling and name-calling....

Reischauer continued by expressing a wish that the legislators would emulate their predecessors who passed the 1965 Medicare Act and write new legislation to make "America's health care system more equitable, more efficient, and less costly." His concerns were prescient: Congress passed no bill in 1994. This suggests a fascinating question: how did the Congressional Budget Office estimate the effects of the PPACA when the congressional practice of "semantic mud wrestling and name-calling" had greatly increased from its prior level? The short answer is that during consideration of both the Clinton health proposal and the PPACA, CBO's staff persevered despite an extraordinary workload and substantial political pressure to change its projections, the agency has a strong culture of independence and high-quality analysis.

There were many factors that produced the PPACA, but one was the increased capacity of the CBO to project the effects of major health policy changes. Besides the cost estimates mentioned above, CBO produces macroeconomic forecasts, policy analysis on major programs, and baseline projections and scorekeeping reports. The baseline is particularly important—it is a projection of spending and revenues under current law that is used to evaluate proposed changes to policy.

In 2007, CBO Director Peter Orszag, in anticipation of major health legislation, successfully requested from appropriators more funding to hire additional experts in health policy and budgets. These staff proceeded to build a sophisticated health insurance simulation model designed to estimate the effects on the budget and on insurance access from many possible changes to health policy. The model combined data from numerous sources—on business firms, federal programs, federal taxes,
With fifty state governments and almost forty thousand general purpose local governments in the United States, it is impossible to provide a succinct explanation of how these different governments budget for health. Perversely vary substantially across governments; in some, the chief executives—governors, county executives, mayors—are relatively powerful; in others, legislative bodies have comparable powers. In most governments, however, the basics of state and local budgeting resemble the federal government—the executive requests a comprehensive budget with the assistance of a central budget office, and then the legislature reviews, amends, and enacts a budget.

As with federal budgeting, there is widespread concern about how health spending may threaten fiscal sustainability.

Many state and local governments have promised health insurance benefits to their retirees, and accounting guidelines now require that more attention be paid to these “other post-employment benefits” (OPEBs). Few governments have set aside funds to cover their OPEB liabilities, which are very costly, especially when added to the liabilities presented by the many unfunded pension plans. The new rules have led some governments to reduce their planned health benefits, many more will follow.

Long-term projections also show very large expenditures over the next few decades from Medicaid spending. Most state leaders believe that controlling costs while maintaining and improving services for the growing population assisted by Medicaid will be a daunting challenge. Yet to many, that and health providers—and used weights drawn from a voluminous review of empirical studies to estimate the effects of policy proposals. To build confidence in its approach, and to educate legislators about the policy tradeoffs, during 2007 and 2008, CBO released technical information about its modeling and two comprehensive reports: “Key Issues in Analyzing Major Health Insurance Proposals” and “Budget Options: Health Care.” While CBO’s analysis of the Clinton proposal discussed important administrative challenges of implementation, this topic received less attention during the PPACA’s consideration.

Another difference from the Clinton approach was that President Obama largely deferred to Congress about the details of health reform, after he established major principles that he said should guide the reform. Obama also hired Orszag to be his OMB director. The five authorization committees with primary jurisdiction over health began to draft legislation, and they repeatedly requested informal estimates from CBO about the effects of their proposals. Those proposals that cost “too much” or that covered “too few” from the perspectives of their authors were modified or dropped. “Too much” was also guided by CBO’s informal pledge to keep the total increase in spending for health care no more than (an arbitrary target of) $900 billion over a ten-year period and by the president’s pledge and the paygo requirement that the PPACA not increase the deficit over this span. The PPACA as enacted met those targets and was also projected to produce significant savings in the second decade of its implementation.

Though CBO’s numbers were used to determine whether the legislation was affordable, these projections were also highly uncertain. It is impossible to predict with high confidence the behavior of providers, patients, and government administrators when legislation creates policies that are substantive changes from current practice. CBO exhibited the natural estimating caution of budget agencies by crediting the legislation with budget savings only when there was substantial evidence that those savings would likely occur, upsetting proponents of health reform.

The uncertainty of projections increases the longer are the periods they cover. As required by statute, CBO provided point estimates of budgetary effects for individual provisions of the bill over the first ten-year period, but for the second decade, it estimated only how the total bill would affect government health care spending as a percentage of gross domestic product. CBO also repeatedly warned Congress that there were relatively large ranges around some of its point estimates.

One of the major financing sources for the PPACA came from reducing payments to Medicare Advantage comprehensive health plans, which many experts said were too generous. This both reduced the future expenditures of the Medicare hospital insurance trust fund and offset some of the costs of expanding access through Medicaid and exchange subsidies, leading to a dispute over whether this was “double-counting.” The law also included a voluntary long-term care insurance program, the CLASS Act; premiums for the program would be collected in the first decade of PPACA implementation, helping to offset the projected effect of access expansion on the deficit. However, the CLASS Act also would lead to long-term outlays; the law would go into effect only if projected after passage of the PPACA to be actuarially sound. That it would not be was predictable given its voluntary participation, and HHS decided not to implement it. That was only one of many actions by HHS since passage of the law, actions that have led to revisions in CBO’s original projections, though the law is still projected to reduce the deficit.
problem is also an opportunity, for the states in effect run fifty different Medicaid programs. While important federal standards exist, the states have great flexibility in designing their programs, subject to approval from HHS through several waiver processes.

This diversity of Medicaid was increased by the Supreme Court's decision in National Federation of Independent Business v. Sebelius (2012), in which it determined by a 5–4 vote that the Patient Protection and Affordable Care Act was a constitutional exercise of the taxing power. The other important holding in this case, by a 7–2 vote, was that the PPACA's expansion of Medicaid could not be forced on the states. The PPACA provides very generous terms to the states for expanding the population covered by Medicaid, for those with incomes up to 138 percent of the federal poverty line: the full costs of expansion are covered by the federal government for the first three years and phased in to 90 percent thereafter. Yet partisan opposition to President Obama and ideological opposition to an expanded federal role in health insurance led twenty-one states, as of July 2013, to decide not to expand Medicaid, with six additional states undecided. Should all of these states decide not to participate, nearly two-thirds of those uninsured who would have been covered by the Medicaid expansion would still lack coverage. The loss of federal funds to these twenty-seven states has been estimated to total almost $600 billion over ten years. Nonparticipating states will also bear larger costs for covering uncompensated care. That so much money would be left on the table suggests that many of the reluctant states will eventually join the expansion.27

REFORM THAT COULD IMPROVE HEALTH BUDGETING

Improvements to government budgeting will clearly be needed if the United States is to promote government financial sustainability and improve policymaking for health. While there are many good reasons for having an annual budget process, it is not well suited to planning and executing a major reform such as the PPACA.

In particular, there will need to be recognition that if governments are to budget sensibly for health, they must take an integrated view of the very complex health sector of society. One promising but politically controversial approach would be to reorganize what is now a very fragmented congressional committee system into one that empowers a Committee on Health in each body. That committee would respond to a periodic review of the health sector by the executive branch. The review would be a substantial expansion of the approach required by the GPRA Modernization Act, and it would use what can be learned from implementation of the PPACA. The review would assess health outcomes in the country and propose formal objectives for improving those outcomes. Based on the results of evidence-based studies, it would suggest how existing spending programs, tax preferences, and regulations could be modified, supplemented, and/or eliminated to foster attainment of health policy goals.28 With this framework, the allocation of budgetary resources to health programs would have a stronger connection to national priorities and to science. Over the long run, it could evolve into a process covering both the public and private sectors, setting a global health sector budget, and using all-payer rate setting.29

See also Chapter 3: The Department of Health and Human Services: Responsibilities and Policies (1953–Present); Chapter 4: The Centers for Disease Control and Prevention: Anticipatory Action in the Face of Uncertainty (1946–Present); Chapter 5: Food and Drug Administration (1962–Present); Chapter 6: The Centers for Medicare and Medicaid Services (1965–Present); Chapter 7: The

A political cartoon expresses the view that U.S. health care costs continue to rise unabated. One goal of the Patient Protection and Affordable Care Act of 2010 was to control rising costs, but many observers doubt that stable health care costs will occur, in part because of people's expectations, which often demand the best and thus most expensive treatment.


Chief Justice John Roberts (in office 2005—) wrote the majority opinion. Following are excerpts of the ruling that the Patient Protection and Affordable Care Act's Medicaid expansion could not be forced on the states:

The States also contend that the Medicaid expansion exceeds Congress's authority under the Spending Clause. They claim that Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State's Medicaid grants, unless the State accepts the new expanded funding and complies with the conditions that come with it. This, they argue, violates the basic principle that the "Federal Government may not compel the States to enact or administer a federal regulatory program."...

In this case, the financial "incentive" Congress has chosen is much more than "relatively mild encouragement"—it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that "further payments will not be made to the State." 42 U.S.C. §1396c. A State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely "a relatively small percentage" of its existing Medicaid funding, but all of it. The States contend that the expansion is in reality a new program and that Congress is forcing them to accept it by threatening the funds for the existing Medicaid program. We cannot agree that existing Medicaid and the expansion dictated by the Affordable Care Act are all one program simply because "Congress styled" them as such... If the expansion is not properly viewed as a modification of the existing Medicaid program, Congress' decision to so title it is irrelevant.

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage. As we have explained, "[T]hough Congress' power to legislate under the spending power is broad, it does not include surprising participating States with postacceptance or "retroactive" conditions..."

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.

Associate Justice Ruth Bader Ginsburg (in office 1993—), joined by Associate Justice Sonia Sotomayor (in office 2009—), dissented from the majority opinion about the Medicaid expansion. Following are excerpts from her opinion:

The Chief Justice... for the first time ever—finds an exercise of Congress' spending power unconstitutionally coercive.

Medicaid, as amended by the ACA, however, is not two spending programs: it is a single program with a constant aim—to enable poor persons to receive basic health care when they need it. Given past expansions, plus express statutory warning that Congress may change the requirements participating States must meet, there can be no tenable claim that the ACA fails for lack of notice. Moreover, States have no entitlement to receive any Medicaid funds; they enjoy only the opportunity to accept funds on Congress' terms. Future Congresses are not bound by their predecessors' dispositions; they have authority to spend federal revenue as they see fit. The Federal Government, therefore, is not, as The Chief Justice charges, threatening States with the loss of "existing" funds from one spending program in order to induce them to opt into another program. Congress is simply requiring States to do what States have long been required to do to receive Medicaid funding: comply with the conditions Congress prescribes for participation.

Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably. Compared to past alterations, the ACA is notable for the extent to which the Federal Government will pick up the tab... Nor will the expansion exorbitantly increase state Medicaid spending... Finally, any fair appraisal of Medicaid would require acknowledgment of the considerable autonomy States enjoy under the Act.

The starting premise on which The Chief Justice's coercion analysis rests is that the ACA did not really "extend" Medicaid; instead, Congress created an entirely new program to co-exist with the old. The Chief Justice calls the ACA new, but in truth, it simply reaches more of America's poor than Congress originally covered... Even if courts were inclined to second-guess Congress' conception of the character of its legislation, how would reviewing judges divine whether an Act of Congress, purporting to amend a law, is in reality not an amendment, but a new creation? At what point does an extension become so large that it "transforms" the basic law?

At bottom, my colleagues' position is that the States' reliance on federal funds limits Congress' authority to alter its spending programs. This gets things backwards: Congress, not the States, is tasked with spending federal money in service of the general welfare. And each successive Congress is empowered to appropriate funds as it sees fit. When the 110th Congress reached a conclusion about Medicaid funds that differed from its predecessors' view, it abridged no State's right to "existing," or "pre-existing" funds.


FURTHER READING


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